2005 Call Letter Frequently Asked Questions

The following questions and answers have been developed to assist in the 2005 Call Letter instructions. These questions have either been posed to CMS staff or developed in anticipation of questions that may be asked. We will continue to respond to questions as they are presented. The date next to the question indicates when it was posted on this web site.

Calendar for the 2005 MA and Medicare Cost Plan Renewal Process

Q1: 07/16/2004 The Renewal Calendar states that December 17 is the final date for organizations to send non-model EOCs to the Regional Offices for review. It then says that model EOCs need to be to the Regions by January 23, 2005. Is this date correct?

A1: 07/16/2004 No. The correct date should be January 21, 2005. However, as we state in the Call Letter, all organizations are encouraged to submit all EOCs to CMS in advance of this date to ensure adequate time to review, approve and print EOCs in time for the February 1, 2005 mailing date.

Part I. Statutory and Regulatory Information

Definition of MA PPO Plan Type

Q1: 08/20/2004 Can you please clarify the following paragraph from pages 1 and 2 of the 2005 Call Letter? It appears in the "Definition of MA PPO Plan Type" section.

"This means that a plan which is identified to beneficiaries as an MA PPO plan must provide reimbursement for **all** covered services – both in- and out-of-network. An MA organization cannot "cap" or otherwise restrict payment for covered services under a PPO plan simply because those services were provided by or received from a non-contracting provider. Nor can an MA PPO plan limit or restrict out-of-network access for covered services. MA organizations are permitted to impose higher cost sharing on PPO plan enrollees for non-emergent out-of-network services. However, annual, lifetime or other limits on payment for out-of-network services are not permitted to the extent that they do not also apply to in-network services of the same type and only to the extent that they are consistent with original Medicare coverage limits and/or the plan's PBP."

A1: 08/20/2004 The statute is clear in requiring MA PPO plans to provide reimbursement for all covered benefits, regardless of whether they are received in- or out-of-network. This includes all benefit types – both basic benefits, which includes Medicare A/B benefits and additional benefits, and supplemental benefits (both mandatory and optional). Plans are permitted to restrict reimbursement or payment for out-of-network covered benefits to an "allowance" for that particular service. For instance, an MA organization can express cost-sharing or beneficiary copayment responsibility related to receipt of an out-of-network covered service by a PPO enrollee as follows: "We will pay the first $25 and you will be responsible for the remainder of the billed amount. The difference between the billed amount and our $25 "allowance" is your responsibility."

The additional discussion on the prohibition of imposing "caps" or restrictions on reimbursement or "payment" for out-of-network services that do not apply to in-network services is simply meant to reinforce the notion that reimbursement must be provided for

all out-of-network services that would be covered benefits if received within the network of contracted providers. Similarly, "annual, lifetime or other limits" cannot be imposed on out-of-network services to the extent that they do not apply to in-network services. Generally, Medicare statutory limits on benefits are related to the duration or number of covered services. Examples of "limits" under the original Medicare program are SNF coverage (100 days per Benefit Period) and inpatient hospital coverage (90 days per Benefit Period – with the possibility of an additional 60 days/lifetime). As you know, MA organizations are not permitted to limit MA plan coverage to levels below original Medicare coverage. In a similar manner, MA PPOs cannot limit out-of-network coverage of benefits to levels below what they offer as benefits in-network. The actual reimbursement by an MA organization for out-of-network benefits (and the copays imposed on members) can, however, be at different levels.

Q2: 08/20/2004 Please explain the cost-sharing guidelines and how they apply to out-of-network benefits? In addition, what is the relationship of the "cap" as described in this section and the "cap" restriction outlined in question 1 above?

A2: 08/20/2004 In recent years CMS has seen a trend toward higher cost-sharing that has raised concerns relative to certain health care services. The guidance in the 2005 Call Letter is to assist organizations as they design benefit plans and to provide information on how CMS will review these benefit designs. We note in this section that CMS will focus on high cost sharing for *Medicare-covered* benefits and that CMS will not approve benefit designs that have the effect of discriminating based on health status. One of the factors that CMS will use in its review of cost sharing is whether a plan has established a maximum out-of-pocket amount, or "cap" to limit member liability. Please note that the annual cap on out-of-pocket expenses of $2,710 in 2005 is; 1) voluntary – provision of such a cap on beneficiary cost sharing simply ensures that CMS will allow more latitude to an MA organization imposing cost-sharing for specific Medicare-covered benefits in an MA plan at levels greater than FFS; 2) applies only to Medicare-covered services; and 3) that CMS allows variation from this published guidance with an appropriate rationale.

It is also important to note that cost-sharing guidance is intended to apply to in-network benefits offered in MA plans. To the extent that cost sharing related to receipt of out-of-network Medicare-covered benefits does exceed FFS levels (and to the extent that cost sharing related to in-network receipt of Medicare covered benefit does **not** exceed FFS levels), reviewers generally will not question a plan's cost-sharing structure.

As discussed above, the use of a "cap" in a benefit design is to limit beneficiary out-of-pocket expenses and is not intended to detract from the statutory requirements that cover the definition of an MA PPO. In an MA PPO plan design an organization cannot limit (or cap) any covered service to the extent that a limit (or cap) is not also applicable to in-network services (Medicare limits notwithstanding).

Part II. Administrative Changes and Updates

Drug Formulary Policy

Q1: 07/26/2004 Does the drugs exception policy apply to open or just closed formularies?

A1: 07/26/2004 It applies to both.

Part III. Renewal Process for 2005

Section 3. Marketing

Q1: 07/16/2004 Part III, Section 3 of the Call Letter states that all members, including employer group members, must receive a 2005 Annual Notice of Change (ANOC) and Summary of Benefits (SB) by October 31 (or December 1 for Cost Plans). However, some organizations have employer group contracts that renew later than January 1 and in those cases, the SB could not reflect any changes other than the one Original Medicare benefit that has been added to the 2005 SB. Therefore, will CMS allow organizations to only send an ANOC to members of employer groups if the employer group contract renews after January 1?

A1: 07/16/2004 We agree that when an employer group contract renews after January 1, it would not make sense to provide a complete SB to the employer group members. Thus, if an organization's contract with an employer renews after January 1, 2005, we will require that only the 2005 ANOC be sent to the employer group members. The 2005 SB would go to these members at least 30 days prior to the beginning of the employer group contract.

If the employer group contract renews on January 1, 2005, we would still expect both the 2005 ANOC and 2005 SB to be sent to the employer group members.